



**MONTANA  
TEACHERS' RETIREMENT SYSTEM**

1500 E 6TH AVE  
PO BOX 200139  
HELENA MT 59620-0139  
406 444-3134

**EMPLOYER PAYROLL INSURANCE  
REPORTING SIGN-UP FORM**

TRS Office Use Only

ALL REQUESTED INFORMATION MUST BE TYPED OR PRINTED LEGIBLY IN DARK INK.

Completion of this form certifies that you are authorized to access and maintain payroll insurance records utilizing the Montana Teachers' Retirement System (TRS) on-line Payroll Insurance Reporting system.

**Employer's Payroll Insurance Contact Information:**

\_\_\_\_\_  
(Employer's Printed Name)

\_\_\_\_\_  
(TRS Six-Digit Employer Number)

\_\_\_\_\_  
(Payroll Insurance Contact Printed Name)

\_\_\_\_\_  
(Area Code and Telephone Number)

\_\_\_\_\_  
(Area Code and Fax Number)

\_\_\_\_\_  
(E-mail Address)

\_\_\_\_\_  
(Employer's Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code))

**Process Insurance Warrant Payable To:**

\_\_\_\_\_  
(Employer's Name **or** Insurance Carrier's Name)

I understand that prior to implementation all payroll insurance deductions must be authorized, in writing, by the TRS benefit recipient directly to the TRS. I am responsible for maintaining current and correct deductions. I will follow the terms and conditions of using the TRS on-line Payroll Insurance Reporting systems.

I hereby certify the above information is correct and authorize the Montana TRS to create an account to maintain payroll insurance deductions.

\_\_\_\_\_  
(Employer's Certifying Officer's Printed Name)

\_\_\_\_\_  
(Employer's Certifying Officer's Signature)

\_\_\_\_\_  
(Date)

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,  
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST